STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
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May 15, 1980

ALL-COUNTY LETTER NO. 80-30

TO: ALL COUNTY WELFARE DEPARTMENTS

SUBJECT: IN-HOME SUPPORTIVE SERVICES NEEDS ASSESSMENT FORMS SOC 293 AND SOC 293 HY

REFERENCE:

This letter transmits a new In-Home Supportive Services Needs Assessment form (SOC 293), a Need Assessment Form for Heavy Cleaning and Yard Hazard Abatement (SOC 293 HY), and instructions for completing the forms. As you may be aware, the In-Home Supportive Services (IHSS) Forms Task Force was established by this Department in September 1979. Its purpose is to review the IHSS forms system, maintain current forms development, and eliminate unnecessary paperwork. The Task Force consists of eight county representatives and one state representative. County members are program administrators and first line supervisors. The Task Force has reviewed the Needs Assessment form and has developed these revised forms and instructions.

MPP 30-461.27 requires that counties use the need assessment form developed or approved by the Department. Effective sixty days from the date of this letter, the SOC 293 (2/80) and SOC 293 HY are the state developed forms for In-Home Supportive Services Needs Assessments as provided in MPP 30-461.27. Counties may order forms through the State Warehouse or duplicate the attached copies. Counties preferring to separate the SOC 293 into two pages, reproduce the forms on NCR paper, or reproduce on legal size paper are free to do so. The instructions will not be available through the warehouse.

This letter also rescinds all existing approvals, for the use of county-developed IHSS Needs Assessment forms sixty days after the date of this letter. Any initial needs assessment or subsequent periodic assessment performed sixty days after the date of this letter must be recorded on the SOC 293 (2/80) and SOC 293 HY unless new approvals of county forms have been secured by that date.

We will amend Division 30-461.271 which requires recipient ethnicity and primary language on the Needs Assessment form. This information is still required in the case file, but may be recorded on another document such as the application form or a facesheet in the file.

If you have any questions, please contact your Adult Services Program Operations Consultant.

JAMES H. GOMEZ
Deputy Director

Attachments

INSTRUCTIONS FOR COMPLETION OF IN-HOME SUPPORTIVE SERVICES

NEEDS ASSESSMENT FORM SOC. 293

Purpose: The SOC 293 is the state developed Needs Assessment Form for In-Home Supportive Services.

The SOC 293 shall be used to determine the need for IHSS consistent with state regulations, to evaluate the recipient's limitations, to identify available alternative resources, and to determine services which shall be purchased through IHSS.

HEADING OF FORM

Date of Home Visit

Enter date of home visit made for the completion of this assessment.

Type of Assessment

Check the appropriate box to identify the type of assessment.

New is used for a new application or a reapplication such as a case previously terminated and again requesting IHSS.

Periodic is used for the mandatory interval assessments required prior to the end of the authorization period.

Change is used when the recipient's circumstances have altered and another assessment is necessary (Div. 30-461.213). A brief comment should be included at the bottom of the page to explain what changed, i.e., health changes, or change in living arrangements.

Emergency is used when the recipient meets the eligibility criteria and requires immediate provision of service (Div. 30-459.8).

Section A. Recipient Identification

The information in this section is self-explanatory.

The space for age requires the recipient's age at the time of the assessment. Date of birth is recorded on the application and since the age at assessment is always calculated out, age is more appropriate; i.e., "The recipient is 77 years old" is more useful than "the recipient was born in 1903."

Companion cases are recipients residing in the same household. This information should always be included since changes in circumstances in one case may require an adjustment in the companion case.

G. Comments/Special Instructions

Use as needed: i.e., to explain exceptions in authorizing Yard Hazard Abatement in shared living arrangements, to calculate total costs to be sure that the cost does not exceed the state maximum payment levels.

H. Signatures

To be signed by social service staff who have performed the assessment, line supervisors, or other staff as required by the county.

County Use Only

To be used for any additional information the county requires.

Using the horizontal columns "Total Need" through "Unmet Needs" enter the appropriate number of hours. These amounts will be per instance. (Refer to SOC 293 instructions for Section F.)

In shared living arrangements, Heavy Cleaning is prorated to all the housemates for common living areas. The recipient's need will be his/her prorated share. If this is an assessment for an area used solely by the recipient, the assessment will be based on the recipient's individual need (Div. 30-463.231). Refer to previous exceptions for landlord/tenant, and shared living arrangements and to Div. 30-463.231, 463.24.

9. Authorization Factors

Indicate the reason for authorization of Heavy Cleaning. A brief comment is required for the three special authorizations in Item c., d., or e. (Div. 30-457.2).

D. Yard Hazard Abatement

1. Date of previous authorization - self-explanatory. If none, so state.

2-4. Using the horizontal column "Total Need" through "Unmet Needs" enter appropriate number of hours per instance. (Refer to SOC 293 instructions for Section F.)

Yard Hazard Abatement may not be authorized in shared living arrangements except when all housemates fall into one or more of the following categories (Div. 30-463.235):

(1) Other IHSS recipients unable to provide services.

(2) Other persons physically or mentally unable to provide services.

(3) Children under 14 years of age.

A brief statement in the comments section should explain any of these situations.

E. Authorization Total

This section is to reconcile the Heavy Cleaning/Yard Hazard Abatement with the other services indicated on the SOC 293. This section will show one grand total of the IHSS hours for this particular instance. Remember that Heavy Cleaning and Yard Hazard Abatement services are not authorized each month but per instance only.

Hours multiplied by the payment rate may be calculated in the comments section to ensure the cost does not exceed program maximum payment levels.

F. Service Delivery Method

Check appropriate box.

INSTRUCTIONS FOR COMPLETION OF IN-HOME SUPPORTIVE SERVICE NEEDS ASSESSMENT FORM FOR HEAVY CLEANING AND YARD HAZARD ABATEMENT (SOC 293HY)

Purpose: The SOC 293HY is the state developed form to be used to assess the need for Heavy Cleaning and Yard Hazard Abatement after completion of the SOC 293. The SOC 293HY is supplemental to the SOC 293 and shall be used consistent with state regulations.

A. Recipient Identification

All items are self-explanatory and should match the information recorded on the SOC 293. Companion cases are recipients residing in the same household and changes in circumstances in one case may require an adjustment in the companion case.

B. Living Arrangements

Check the correct situation.

Independent: Recipient lives alone.

If shared living, adjustments and proration should be made to Heavy Cleaning in Section C (Div. 30-463.231).

If Landlord/Tenant and the recipient is the tenant the need for Heavy Cleaning is based on the living area used solely by the recipient and Yard Hazard Abatement is unallowable (Div. 30-463.241a). If the recipient is the landlord, need for Heavy Cleaning is assessed for all areas except those which are used solely by the tenant (Div. 30-463.241b).

If the recipient resides in a relative's home primarily to receive services the need for Heavy Cleaning services shall be assessed only for the living areas used solely by the recipient and Yard Hazard Abatement services cannot be provided (Div. 30-463.242).

If other is checked, briefly explain the arrangement.

A brief explanation of the living arrangement and how it affects the authorization of either Heavy Cleaning or Yard Hazard Abatement should be made in Comments, Section G.

C. Heavy Cleaning

1. Date of Previous Authorization

Self-explanatory; if none, so state.

2-8. Review the list of available Heavy Cleaning Services and eliminate from consideration services the recipient can perform safely and without unreasonable stress and any services clearly not needed.

Section B. Functional Assessment

1. Recipient's Statement of Need

Summarize the recipient's statement. Describe briefly what he says about the need for IHSS. Provide a concise picture of the recipient's situation from the recipient's own viewpoint.

2. Physical Functioning

This section considers a joint assessment by the recipient and the social service staff. In certain cases, more than one item may be checked. If so, explain in comments - i.e., when checking "with appliance" it might also be correct to check "with human support" if someone else's help to operate the appliance is needed; or "some difficulty" might be checked if the recipient can operate the appliance with some difficulty. The following definitions should be considered for this evaluation:

With Ease - Recipient has no difficulty, or is "normal" in functioning for the factor listed. "Normal" means average or better ability without qualification.

Some Difficulty - This suggests "Some" to "Moderate" or "Occasional" impairment in functioning. For example, if the recipient is 94 years old and walks slowly and stiffly, she has "some difficulty". (This is the correct coding, even though her walking ability might be considered "normal for her age".)

Very Difficult - Suggests the recipient is significantly impaired in one or more areas of functioning. Coding should be used when recipient can manage on own with great amount of effort and when recipient needs some assistance in functioning. Should also be used if it is painful for recipient to function.

The next two categories involve use of some support to enable the recipient to function. Although there are two categories, they may overlap.

With Human Support - Used if the recipient is unable to manage an area of physical functioning unless someone is there to help him. For example, a person who cannot lift himself out of bed without the assistance of another.

With Appliance - Used if the recipient's functioning depends upon the working availability of a particular life-support device, appliance or home modification. For example, a severe emphysema victim may only be able to breathe with the use of a machine.

Not at All - Used where the recipient's functioning is nonexistent in one or more areas; for example, total blindness, total deafness.

3. Mental Emotional Functioning

When completing this section, use the criteria previously suggested to evaluate the physical factors in Section B 2. The mental/emotional factors are:

Memory - Can recipient remember immediately past events? Can he remember to pay bills, to cash checks, where belongings are kept? Can he identify significant other persons?

Orientation - This section asks how well oriented the recipient is to his surroundings, to his environment, to other persons around him. Does he lose his way when he goes shopping? Is he in touch with current reality (time, place, person)? Does he wander or get lost?

Cooperation - Does the recipient have trust or regard for others? Is he suspicious or fearful around others? Does he retain a flexibility in dealings with others? Does the recipient need a great amount of encouragement or persuasion to get along with others? Does he reject assistance, insist on independence even when this may be self-endangering? Is he completely resistive to or withdrawn from human contact by choice? Is he active socially?

Decision Making - When making a decision, how self-reliant, self-confident is the recipient? Does he need consultation with others (family, friends) to make choices? Can recipient make own decisions most often, but requires consultation for major choices or must he rely totally on others? To what extent do his impairments prevent decision making? Does he waiver excessively when a decision has been reached or can he stick to it? Is he aware of what information is required to reach major/minor decisions?

4. Emergency Contacts/Instructions

Name, address, phone and relationship to recipient of emergency contact.

5. Special Conditions/Factors

List factors significant to the recipient's situation or condition. May include dependence on alcohol or drugs, habits which are endangering to health or safety, allergies, special diets, previous hospitalization dates, frequency of medical visits or any other information the county deems pertinent.

6. Medical Information

Enter only information which is relevant to the assessment. If there is no medical information, so state or state "not applicable" if this is not pertinent to this recipient.

Date of Request

Enter the date medical verification was requested. The request may be cross-referenced to a physician by using an asterisk (*).

Diagnosis/Prognosis

From the available medical information, state primary diagnosis/prognosis.

Physicians and Phone #s

List all current physicians. This information is especially useful when assessing need for medical transportation - what doctor does the recipient see, how often, etc.

Medications

From available information, list prescription drugs, purpose, the prescribing doctor and dosage. This information may be useful in explaining behavioral changes, i.e., if recipient is overmedicating himself and sleeps most of the time or if recipient becomes extremely irritable and sensitive when medication is not taken.

C. Living Arrangements

1. Type of Residence. Self-explanatory.

2. Number of Room:

Usually entryways, hallways, closets, foyers, basements, porches, and garages are not counted as separate rooms. If there is an exception, explain in the Comments section; i.e., a recipient has the front entryway partially converted to a bedroom and sleeps there during the day. In this case, it may be counted as a bedroom.

3. Facilities - self-explanatory.

4. Yard - self-explanatory.

5. Special Conditions in Living Arrangements

(Div. 30-453 - Special Definitions)

Independent - recipient lives alone.

Shared Living Arrangement exists in the situation where one or more recipients reside in the same residence with one or more other persons.

Live-In-Provider - means a provider who is not related to the recipient and who lives in the recipient's home expressly to provide IHSS services.

Landlord/tenant is a type of shared living arrangement which exists when one housemate (landlord) allows another (tenant) to share the residence in return for monetary or in-kind payment to the landlord. This arrangement is not recognized for a live-in provider. Where housemates share the residence merely to share expense the landlord/tenant arrangement does not exist.

Other may be used to specify a minor child living in the parent's home or any other situation. Should be explained briefly.

6. Other Persons in Household

List all other persons living with recipient. May specify which days or hours the person is in school, i.e., Monday, Tuesday, Wednesday 8:00-1:30. In the Limitations section cite the specific reason why this person cannot provide IHSS to the recipient, i.e., refuses, physically unable, etc.

D. Alternate Resources

List the available service and source, i.e., Meals-on-Wheels through Senior Help Agency. If none are available to the recipient, so state.

E. Help to Obtain Provider

Self-explanatory.

F. Services

Frequency per week may be noted beside the service, i.e., "preparation of meals" - 3/day.

Domestic Services

Although there are line items for each Domestic Service (a-i) it is permissible to merely check the individual domestic services, bracket the group and enter one aggregate total of weekly hours for all the needed services. It is no longer necessary to calculate hours for each domestic service. However, the aggregate total still must flow through the calculations for total need, adjustments and alternate resources as explained in the following sections.

Total Need

Used to indicate total household need. Review the listed services and eliminate from consideration those services which the recipient can perform safely, without unreasonable stress and those services which are clearly not needed. (Bear in mind the functional assessment criteria in Section B.)

Determine the individual weekly hours needed for all services not eliminated.

Adjustments

Used to separate the recipient's share of the total need from that of other housemates. Prorate among all housemates benefiting from the service unless the recipient is the only beneficiary, in which case no adjustment is needed. MPP, Div. 30-463.23 and .24 explain shared living arrangements and exceptions.

Total Need for IHSS

Derived by subtracting "adjustments" from total household need. If there are no adjustments, the total in this column will be the same as the total household need column. For nonmedical personal services, transportation, and paramedical which are based on individual need, this is the beginning block (Div. 30-463.235).

Alternate Resources

Enter amount of time contributed by someone other than the IHSS provider. As an example, the married daughter of the IHSS recipient brings evening meals to the recipient. In this case, the amount of time which had been previously allotted for this meal preparation is subtracted. Include in this column all alternative resources available from other community agencies, programs or persons. (These alternate resources should be identified in Section D.)

To be Purchased by IHSS

Subtract the alternate resources column and enter the difference as hours being authorized per week.

Unmet Need

This column is used when the "Total Needs for IHSS" exceed the total number of hours "provided by others" and/or the allowable state maximums. This column may also be used to indicate a service need identified by the social worker but refused by the recipient.

Unmet need should be indicated for each individual activity. This documentation can be useful when attempting to increase services.

G. Authorization

1. Level of Service

A severely impaired individual has a total need of twenty hours or more per week in one or more of the following areas - respiration, bowel and bladder care, feeding, routine bed baths, dressing, menstrual care, ambulation, moving into and out of bed, meal preparation, and/or paramedical services.

2. Service Delivery Method

Check appropriate box.

3. Monthly Hours Authorized

Self-explanatory.

4. Authorization Period

Indicate beginning and ending dates of authorization based on this assessment. This period can be for no longer than the statutory maximum and should be for a shorter period if the need is short-term or expected to change.

5. Signature(s)

To be signed by the worker performing the assessment and other personnel, at the county option, for example MSRTs, or supervisors.

IN-HOME SUPPORTIVE SERVICES
NEEDS ASSESSMENT

DATE OF HOME VIS

☐ NEW ☐ CHANGE
☐ PERIODIC ☐ EMERGENCY

A. RECIPIENT INFORMATION

NAME	CASE NO.	TELEPHONE	AGE	SEX M F

ADDRESS – NUMBER STREET

IHSS COMPANION CASE(S), NAME(S) AND NUMBER(S)

CITY STATE

SPECIAL DIRECTIONS

B. FUNCTIONAL ASSESSMENT

1. RECIPIENT'S STATEMENT OF NEED

2. PHYSICAL FUNCTIONING (CHECK ✓)

	WITH EASE	SOME DIFFICULTY	VERY DIFFICULT	WITH HUMAN SUPPORT	WITH APPLIANCE	NOT AT ALL
Mobility Inside						
Mobility Outside						
Climbing Stairs						
Reaching						
Lifting						
Feed Self						
Bathing						
Dressing						
Grooming						
Transfer						
Bowel and Bladder						
Hearing						
Seeing						
Breathing						

3. MENTAL/EMOTIONAL FUNCTIONING (CHECK ✓)

	NO PROBLEM	MODERATE OR INTERMITTENT	SEVERE PROBLEM	REQUIRES SUPERVISION
Memory				
Orientation				
Cooperation with Others				
Decision Making				

4. EMERGENCY CONTACTS/INSTRUCTIONS

5. SPECIAL CONDITIONS/FACTORS

6. MEDICAL INFORMATION DATE OF REQUEST:

DIAGNOSIS/PROGNOSIS

PHYSICIAN(S)	PHONE NO.	PHYSICIAN(S)	PHONE NO.

MEDICATIONS	PURPOSE OF MEDICATIONS

C. LIVING ARRANGEMENTS

1. RECIPIENT LIVES IN (CHECK ONE)
☐ HOUSE ☐ MOBILE HOME ☐ OTHER (SPECIFY) _____
☐ APARTMENT ☐ HOTEL

2. NO. OF RMS.

3. FACILITIES IN HOME (CHECK)
☐ WASHER ☐ COOKING
☐ CLOTHES DRYER

4. YARD
☐ YES ☐ NO

5. SPECIAL CONDITIONS IN LIVING ARRANGEMENTS (CHECK ONE)
☐ INDEPENDENT ☐ SHARED ☐ LIVE-IN PROVIDER ☐ LANDLORD/TENANT ☐ OTHER (SPECIFY) _____

6. OTHER PERSONS IN HOUSEHOLD:

NAME	AGE	RELATIONSHIP	REC. IHSS YES	REC. IHSS NO	HRS. AT WORK/ IN SCHOOL	LIMITATIONS WHICH PREVENT PROVISION OF IHSS TO RECIPIENT

7. COMMENTS

ECIPIENT'S NAME

PREVIOUS HOURS AUTHORIZED

. ALTERNATE RESOURCES USED

ist source and service provided (if alternate esources not used, explain)

. DOES RECIPIENT NEED HELP TO OBTAIN A PROVIDER?

☐ Yes ☐ No **If yes, explain action taken:**

OMMENTS:

F. SERVICES (HOURS PER WEEK)	Total Need	Adjustments	Total Need for IHSS	Alternative Resources	To Be Purchased By IHSS	Unmet Need
1. DOMESTIC SERVICES						
a. Sweeping, vacuuming, etc.						
b. Washing kitchen counters, etc.						
c. Cleaning bathroom						
d. Storing food and supplies						
e. Taking out garbage						
f. Dusting and picking up						
g. Cleaning oven and stove						
h. Cleaning and defrosting refrigerator						
i. Bringing in fuel and miscellaneous						
SUB-TOTAL						
2. RELATED SERVICES						
a. *Preparation of meals						
b. Meal clean up and menus						
c. Routine mending and laundry, etc.						
d. Changing bed linen and making bed						
e. Shopping for food						
f. Other shopping and errands						
SUB-TOTAL						
3. HEAVY CLEANING (See SOC 293 HY)						
4. NON-MEDICAL PERSONAL SERVICES						
a. *Respiration						
b. *Bowel and bladder care						
c. *Feeding						
d. *Routine bed baths						
e. *Dressing						
f. *Menstrual care						
g. *Ambulation						
h. *Moving into and out of bed						
i. Bathing, oral hygiene and grooming						
j. Rubbing skin, etc.						
k. Care and assistance with prosthesis						
SUB-TOTAL						
5. TRANSPORTATION SERVICES						
a. Medical appointment						
b. To alternative resources						
6. YARD HAZARD ABATEMENT (See SOC 293 HY)						
7. PROTECTIVE SUPERVISION						
8. TEACHING AND DEMONSTRATION						
9. *PARAMEDICAL SERVICES						
10. TOTAL "TO BE PURCHASED BY IHSS" COLUMN						
11. DOES RECIPIENT OPT FOR RESTAURANT ALLOWANCE? ☐ YES ☐ NO IF YES, ENTER TOTAL HOURS FROM 2A, B, E.						
12. TOTAL WEEKLY HOURS (SUBTRACT LINE 11 FROM LINE 10)						

. AUTHORIZATION

LEVEL OF SERVICE (CHECK ONE)

☐ *SEVERELY IMPAIRED (SPECIFY NO. OF HOURS: _____) (TOTAL NEED FROM F 2A, 4 A-H, 9)

☐ NON-SEVERELY IMPAIRED

2. SERVICE DELIVERY METHOD (CHECK)

☐ COUNTY ☐ INDIVIDUAL

☐ CONTRACT AGENCY

MONTHLY HOURS AUTHORIZED

_____ X 4.33 = _____

WEEKLY HOURS (FROM F 12) MONTHLY HOURS

4. AUTHORIZATION PERIOD

_____ TO _____

SOCIAL SERVICE STAFF	DATE	6. APPROVED BY:	DATE
a.		a.	
b.		b.	

COUNTY USE ONLY

IN HOME SUPPORTIVE SERVICES NE S ASSESSMENT
HEAVY CLEANING/YARD HAZARD ABATEMENT

DATE OF HOME VISIT

A. RECIPIENT IDENTIFICATION

NAME		CASE NUMBER	PHONE	AGE	SEX M F
ADDRESS–NUMBER	STREET	IHSS COMPANION CASE(S) NAME(S) AND NUMBER(S)			
CITY	STATE ZIP CODE	SPECIAL DIRECTIONS			

B. LIVING ARRANGEMENTS (✓ APPROPRIATE BOX)

☐ INDEPENDENT ☐ LIVE–IN PROVIDER ☐ OTHER (SPECIFY)

☐ SHARED ☐ LANDLORD/TENANT

C. HEAVY CLEANING HOURS

1. DATE OF PREVIOUS AUTHORIZATION	TOTAL NEED	ADJUST–MENTS	TOTAL NEED FOR IHSS	ALTERNA–TIVE RESOURCES	TO BE PURCHASED BY IHSS	UNMET NEED
2. CLEAN WALL AND CEILINGS						
3. CLEAN CUPBOARDS						
4. SHAMPOO RUGS OR CARPETS						
5. WASH WINDOWS						
6. CLEAN WINDOW COVERINGS						
7. CLEAN UNDER/BEHIND FURNITURE						
8. HEAVY CLEANING TOTAL						

9. AUTHORIZATION FACTORS (Check one)

a. ☐ Annual cleaning of whole house in addition to domestic services.

b. ☐ Semi–Annual cleaning in lieu of domestic services.

c. ☐ * Special authorization due to physical/mental condition.

d. ☐ * Special authorization due to disaster.

e. ☐ * Special authorization because client has moved since last cleaning

* Explanation:

D. YARD HAZARD ABATEMENT HOURS

1. DATE OF PREVIOUS AUTHORIZATION	TOTAL NEED	ADJUST–MENTS	TOTAL NEED FOR IHSS	ALTERNA–TIVE RESOURCES	TO BE PURCHASED BY IHSS	UNMET NEED
2. REMOVE GRASS, WEEDS, RUBBISH						
3. REMOVE ICE, SNOW						
4. YARD HAZARD ABATEMENT TOTAL						

COUNTY USE ONLY

E. AUTHORIZATION TOTAL HOURS

1. TOTAL HOURS AUTHORIZED PER MONTH PER SOC 293 (G–3)	
2. HEAVY CLEANING TOTAL HOURS (C 8)	
3. YARD HAZARD ABATEMENT TOTAL HOURS (D 4)	
4. TOTAL IHSS AUTHORIZED (TOTAL E–1,2,3)	

F. SERVICE DELIVERY METHOD (Check)

☐ COUNTY ☐ INDIVIDUAL ☐ CONTRACT AGENCY

G. COMMENTS/SPECIAL INSTRUCTIONS

SOCIAL SERVICES STAFF	DATE	APPROVED BY	DATE